TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Donald M McPhaul MD

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-15-3305-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This request was in response to a $285.23 reduction of the $930.96 for the EMG/NCV performed on February 26, 2015."

Amount in Dispute: $285.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Gallagher Bassett appropriately denied this service under the explanation code 15, "Payer deems the information submitted does not support this level of service." Gallagher Bassett appropriately denied the service under explanation code 97, "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

Response submitted by: Ricky D. Green, PLLC, 9600 Escarpment Blvd, Ste 745-52, Austin, Texas 78749

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2015	99204, A4556	$285.23	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Payer deems the information submitted does not support this level of service

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

(1) The insurance carrier denied disputed service 99204 with claim adjustment reason code 15 – "Payer deems the information submitted does not support this level of service." 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;"

The Centers for Medicare and Medicaid Services guidelines as it relates to documentation requirements of Evaluation and Management Codes can be found at; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

Review of the submitted "Electromyography (EMG) Report) finds;

Comprehensive

- Documentation of the Comprehensive History
  - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed seven elements of the chronic condition, thus meeting this component.
  - Review of Systems (ROS) inquires about the system (s) directly related to the problem(s) plus additional body systems. At least ten organ systems must be reviewed. Documentation found listed one system, this component was not met.
  - Past Family, and/or Social History (PFSH) require a review of two or all history areas, at least one specific item from each history areas to be documented. The documentation found listed one area, (Past history). This component was not met.
- Documentation of a Comprehensive Examination:
  - Requires at least nine organ systems to be documented, with at least two elements listed per system. The documentation found listed one body/ two organ systems: (Each extremity, and Constitutional, Musculoskeletal). This component was not met.

The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. 28 Texas Administrative Code § 134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;" Procedure code A4556, service date February 26, 2015, has a status code of P – "Bundled / Excluded Code." No additional payment can be recommended.

3. The total allowable reimbursement for the services in dispute is $362.78. This amount less the amount previously paid by the insurance carrier of $645.73 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 23, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.